RECOMMENDATIONS

Co-Chairs: Senator William Purcell, MD Representative Martha Alexander

FINDINGS:

The Joint Study Committee on Hospital Infection Control and Disclosure reviewed information about actions that other states have taken regarding surveillance and reporting of healthcare acquired infections in their states. The landscape of this issue is currently in flux, with much attention and some action being taken at the federal level, and a range of state-level initiatives being implemented across the nation, with varying amounts of success.

Lessons learned from other states' experiences implementing broad, comprehensive surveillance efforts indicated that such efforts were often costly, cumbersome, and frequently failed to produce the desired results (validated information made available to the public in a useful format on a timely basis). In contract, states that pursued incremental approaches reported having achieved positive results regarding rates of infections in their facilities. Given this, the committee recommends that the General Assembly support an incremental approach to the collection and reporting of data on hospital-acquired infections in this State. Building on expertise of existing staff in the Communicable Disease Branch of the Division of Public Health, dedicated staff would be hired to create a system to collect and report on a readily available outcome measure, central-line associated blood stream infections (CLABSI) in hospital intensive care units. The system would then expand to include additional healthcare facilities and additional outcome and process measures as data collection, validation and other system capabilities develop.

The committee stresses the importance that the methodology ultimately implemented provide healthcare facilities with the opportunity to review data and analyses prior to public disclosure of the data (allowing for corrections or explanations to be provided where appropriate), require that comparisons among facilities be adjusted for different patient case mixes and other relevant risk factors, and that other data or analytical limitations be clearly noted when the data is reported. Patient confidentiality shall be preserved at all stages and safeguards against unauthorized use or disclosure of any facility or patient information collected shall be paramount.

In light of these findings, the Joint Study Committee on Hospital Infection Control and Disclosure makes the following recommendations to the 2009 Regular Session of the 2009 General Assembly:

RECOMMENDATION 1:

The Joint Study Committee on Hospital Infection Control and Disclosure recommends implementation of a mandatory, State-operated, Statewide hospital acquired infection